SERFF Tracking Number:	*CHUB-125276253*	*State:*	*Arkansas*
Filing Company:	*Federal Insurance Company*	*State Tracking Number:*	*AR-PC-07-026049*
Company Tracking Number:	*05-AP-8A-F*		
TOI:	*17.1 Other Liability - Claims Made Only*	*Sub-TOI:*	*17.1008 Employee Benefit Liability*
Product Name:	*ESL Stop Loss Supplemntal App Revision*		
Project Name/Number:	*ESL Stop Loss Supp App Revison/05-AP-8 A*		

Filing at a Glance

Company: Federal Insurance Company

Product Name: ESL Stop Loss Supplemntal App Revision	SERFF Tr Num: CHUB-125276253	State: Arkansas
TOI: 17.1 Other Liability - Claims Made Only	SERFF Status: Closed	State Tr Num: AR-PC-07-026049
Sub-TOI: 17.1008 Employee Benefit Liability	Co Tr Num: 05-AP-8A-F	State Status:
Filing Type: Form	Co Status:	Reviewer(s): Betty Montesi, Edith Roberts, Brittany Yielding
	Authors: Diana Cardone, Susan Leonard	Disposition Date: 09/20/2007
	Date Submitted: 09/11/2007	Disposition Status: Approved
Effective Date Requested (New): On Approval		Effective Date (New):
Effective Date Requested (Renewal):		Effective Date (Renewal):

General Information

Project Name: ESL Stop Loss Supp App Revison
Project Number: 05-AP-8 A

Reference Organization:
Reference Title:
Filing Status Changed: 09/20/2007
State Status Changed: 09/11/2007
Corresponding Filing Tracking Number:

Status of Filing in Domicile: Not Filed
Domicile Status Comments: This will be filed in our domiciliary state soon
Reference Number:
Advisory Org. Circular:

Deemer Date:

Filing Description:

RE: Federal Insurance Company

NAIC: 038-20281

FICA: 13-1963496

Employer Stop Loss Our Filing # 05-AP-8A-F

Form #'s Form 14-03-0485 SuppA (8/2007) Supplemental Application

Effective Date: Upon Approval

SERFF Tracking Number:	*CHUB-125276253*	*State:*	*Arkansas*
Filing Company:	*Federal Insurance Company*	*State Tracking Number:*	*AR-PC-07-026049*
Company Tracking Number:	*05-AP-8A-F*		
TOI:	*17.1 Other Liability - Claims Made Only*	*Sub-TOI:*	*17.1008 Employee Benefit Liability*
Product Name:	*ESL Stop Loss Supplemntal App Revision*		
Project Name/Number:	*ESL Stop Loss Supp App Revison/05-AP-8 A*		

We are submitting for approval a revised supplemental applicaton to repalce the form recently submitted and approved under our filing number 05-AP-8 F/R.

This revised Application 14-03-0485-Supp A EMPOLYER STOP LOSS SUPPLEMENTAL APPLICATION allows us to obtain information necessary to underwrite the Stop Loss program.

There is no impact on rating by the use of this form, therefore this filing does not contain any documents pertaining to our rating methods.

Thank you for your attention to this filing. Your approval for policies issued under this program will be greatly appreciated.

Company and Contact

Filing Contact Information

Fran Muldoon, Manager - CPI State Filngs Dept.	fmuldoon@chubb.com	
202 Hall's Mill Rd.	(908) 572-2875 [Phone]	
Whitehouse Station, NJ 08889-9977	(908) 572-4034[FAX]	

Filing Company Information

Federal Insurance Company	CoCode: 20281	State of Domicile: Indiana
202 Hall's Mill Road	Group Code: 38	Company Type:
P.O. Box 1650		
Whitehouse Station, NJ 08889-1650	Group Name:	State ID Number:
(908) 572-4726 ext. [Phone]	FEIN Number: 13-1963496	

Filing Fees

Fee Required?	Yes
Fee Amount:	$20.00
Retaliatory?	No
Fee Explanation:	1 Form =$20.00

SERFF Tracking Number:	*CHUB-125276253*	*State:*	*Arkansas*
Filing Company:	*Federal Insurance Company*	*State Tracking Number:*	*AR-PC-07-026049*
Company Tracking Number:	*05-AP-8A-F*		
TOI:	*17.1 Other Liability - Claims Made Only*	*Sub-TOI:*	*17.1008 Employee Benefit Liability*
Product Name:	*ESL Stop Loss Supplemntal App Revision*		
Project Name/Number:	*ESL Stop Loss Supp App Revison/05-AP-8 A*		

Check # 00364283

Check Date: 09/06/2007

Date Mailed 09/10/07

Per Company: No

SERFF Tracking Number:	*CHUB-125276253*	*State:*	*Arkansas*
Filing Company:	*Federal Insurance Company*	*State Tracking Number:*	*AR-PC-07-026049*
Company Tracking Number:	*05-AP-8A-F*		
TOI:	*17.1 Other Liability - Claims Made Only*	*Sub-TOI:*	*17.1008 Employee Benefit Liability*
Product Name:	*ESL Stop Loss Supplemntal App Revision*		
Project Name/Number:	*ESL Stop Loss Supp App Revison/05-AP-8 A*		

COMPANY	AMOUNT	DATE PROCESSED	TRANSACTION #
Federal Insurance Company	$0.00	09/11/2007	

CHECK NUMBER	CHECK AMOUNT	CHECK DATE
00364283	$20.00	09/06/2007

SERFF Tracking Number:	*CHUB-125276253*	*State:*	*Arkansas*
Filing Company:	*Federal Insurance Company*	*State Tracking Number:*	*AR-PC-07-026049*
Company Tracking Number:	*05-AP-8A-F*		
TOI:	*17.1 Other Liability - Claims Made Only*	*Sub-TOI:*	*17.1008 Employee Benefit Liability*
Product Name:	*ESL Stop Loss Supplemntal App Revision*		
Project Name/Number:	*ESL Stop Loss Supp App Revison/05-AP-8 A*		

Correspondence Summary

Dispositions

Status	Created By	Created On	Date Submitted
Approved	Edith Roberts	09/20/2007	09/20/2007

SERFF Tracking Number:	*CHUB-125276253*	*State:*	*Arkansas*
Filing Company:	*Federal Insurance Company*	*State Tracking Number:*	*AR-PC-07-026049*
Company Tracking Number:	*05-AP-8A-F*		
TOI:	*17.1 Other Liability - Claims Made Only*	*Sub-TOI:*	*17.1008 Employee Benefit Liability*
Product Name:	*ESL Stop Loss Supplemntal App Revision*		
Project Name/Number:	*ESL Stop Loss Supp App Revison/05-AP-8 A*		

Disposition

Disposition Date: 09/20/2007
Effective Date (New):
Effective Date (Renewal):
Status: Approved
Comment:

Rate data does NOT apply to filing.

SERFF Tracking Number:	*CHUB-125276253*	*State:*	*Arkansas*
Filing Company:	*Federal Insurance Company*	*State Tracking Number:*	*AR-PC-07-026049*
Company Tracking Number:	*05-AP-8A-F*		
TOI:	*17.1 Other Liability - Claims Made Only*	*Sub-TOI:*	*17.1008 Employee Benefit Liability*
Product Name:	*ESL Stop Loss Supplemntal App Revision*		
Project Name/Number:	*ESL Stop Loss Supp App Revison/05-AP-8 A*		

Item Type	Item Name	Item Status	Public Access
Supporting Document	Uniform Transmittal Document-Property & Casualty	Approved	Yes
Form	Employer Stop Loss Supplemental Application	Approved	Yes

SERFF Tracking Number:	*CHUB-125276253*	*State:*	*Arkansas*
Filing Company:	*Federal Insurance Company*	*State Tracking Number:*	*AR-PC-07-026049*
Company Tracking Number:	*05-AP-8A-F*		
TOI:	*17.1 Other Liability - Claims Made Only*	*Sub-TOI:*	*17.1008 Employee Benefit Liability*
Product Name:	*ESL Stop Loss Supplemntal App Revision*		
Project Name/Number:	*ESL Stop Loss Supp App Revison/05-AP-8 A*		

Form Schedule

Review Status	Form Name	Form #	Edition Date	Form Type Action	Action Specific Data	Readability	Attachment
Approved	Employer Stop Loss Supplemental Application	14-03-0485-SuppA	8/2007	Application/ Replaced Binder/Enrollment	Replaced Form #: 14-03-0485-SuppA Previous Filing #: 05-AP-8-F	40.90	14-03-0485-Supp Supplemental Application 8-2007.pdf

Chubb Group of Insurance Companies
15 Mountain View Road
Warren, New Jersey 07059

EMPLOYER STOP LOSS SUPPLEMENTAL APPLICATION

HIPAA Privacy permits the release of Protected Health Information (PHI) for the purpose of evaluating and accepting risk associated with the Applicant as a part of "health care operations". The Company shall use the information provided solely for the purpose of evaluating the acceptability of this risk and shall not disclose any PHI collected except in performing this risk evaluation.

The Company will rely upon the information provided on the attached disclosure form, which will become part of the Application for stop loss coverage. The purpose of the form is to allow the Company to take underwriting action on all known risks in the categories listed below. It is the **Applicant**'s responsibility, either directly or through its designated representative, to accurately report all claims known as of the date of this disclosure by making a thorough review of all applicable records. Such records shall include historical claims reports, disability records, current information from administrators, insurers, utilization management companies, managed care companies, and any Agent/Broker utilized by the **Applicant**. In exchange, the Company will accept the liability for any truly unknown risks. The attached disclosure form must be completed and signed by the appropriate parties no more than [thirty (30) days] prior to the proposed Effective Date of stop loss coverage and received by the Company within [five (5) days]of completion.

Upon receipt of the completed disclosure, the Company will assess all data, new and previously reported, and will inform the producer in writing within [five (5) days] of any changes to the rates, factors or terms of coverage. The Company reserves the right to rescind the proposal in its entirety based upon a review of all information submitted during the proposal process.

List on the Disclosure Form all risks known to:

1. Be currently disabled, confined to a medical facility, or have been pre-certified within the last three months.
2. Have received medical services during the current plan year the cost of which exceeds the lesser of, [50%]of the lowest Specific Retention Amount applied for or[$50,000,] and for which bills have been received by the Third Party Administrator (TPA) and entered into their claims system.
3. Have been identified as a candidate for case management and as having the potential to exceed during the policy period, the lesser of, [50%] of the lowest Specific Retention Amount applied for, or [$50,000].
4. Have been diagnosed, during the current plan year, with a condition represented by any of the ICD-9 codes contained in the attached list and have also received medical services costing [$5,000]. during the same period.

It is the responsibility of the **Applicant** to provide accurate responses to 1 – 4 above. The policy excludes coverage for certain catastrophic diagnoses which the **Applicant** fails to disclose. If the **Applicant** fails to disclose any risk known to fall into one of the above categories, either intentionally or because a thorough review of all records was not conducted, then the Company may not have liability for claims on the risk not disclosed.

EMPLOYER STOP LOSS SUPPLEMENTAL APPLICATION

All information disclosed by the Applicant will be treated as confidential by the Company.

Risk Identifier	Date of Birth	Sex	EE, Spouse or Child	(A)ctive, (C)OBRA, (R)etiree, or (T)ermed	Termination Date	Diagnosis	Most Recent Date of Service	Expenses Incurred This Plan Year

By its signature at the end of this application, the **Applicant** represents that the above list accurately discloses all risks in accordance with the instructions attached to this form, and that it is the result of a thorough review in accordance with those instructions. **If there are no risks to report which meet the disclosure criteria above, please check this box.** ☐

Material Change: If there is any material change in the answers to the questions in this Supplemental Application before the Policy inception date, the **Applicant** must immediately notify the Company in writing, and any outstanding quotation may be modified or withdrawn.

Notice to Arkansas, Louisiana, Maryland, Minnesota, New Mexico and Ohio Applicants: Any person who, with intent to defraud or knowing that he/she is facilitating a fraud against an insurer, submits an application or files a claim containing a false, fraudulent or deceptive statement is, or may be found to be, guilty of insurance fraud, which is a crime, and may be subject to civil fines and criminal penalties.

Notice to Colorado Applicants: It is unlawful to knowingly provide false, incomplete or misleading facts or information to an insurance company for the purpose of defrauding or attempting to defraud the company. Penalties may include imprisonment, fines, denial of insurance, and civil damages. Any insurance company or agent of an insurance company who knowingly provides false, incomplete, or misleading facts or information to a policy holder or claimant for the purpose of defrauding or attempting to defraud the policy holder or claimant with regard to a settlement or award payable from insurance proceeds shall be reported to the Colorado Division of Insurance within the Department of Regulatory agencies.

Notice to Maine, Tennessee and Virginia Applicants: It is a crime to knowingly provide false, incomplete or misleading information to an insurance company for the purpose of defrauding the company. Penalties may include imprisonment, fines or a denial of insurance benefits.

Notice to District of Columbia WARNING: It is a crime to provide false or misleading information to an insurer for the purpose of defrauding the insurer or any other person. Penalties include imprisonment and/or fines. In addition, an insurer may deny insurance benefits if false information materially related to a claim was provided by the applicant

Notice to Florida and Oklahoma Applicants: Any person who, knowingly and with intent to injure, defraud or deceive any employer or employee, insurance company, or self-insured program, files a statement of claim containing any false or misleading information is guilty of: a felony (in Oklahoma) or a felony of the third degree (in Florida).

Notice to Kentucky Applicants: Any person who, knowingly and with intent to defraud any insurance company or other person files an application for insurance containing any false information, or conceals for the purpose of misleading, information concerning any material fact thereto, commits a fraudulent insurance act which is a crime.

Notice to New Jersey Applicants: Any person who includes any false or misleading information on an application for an insurance policy is subject to criminal and civil penalties.

Notice to Oregon and Texas Applicants: Any person who makes an intentional misstatement that is material to the risk may be found guilty of insurance fraud by a court of law.

Notice to New York and Pennsylvania Applicants: Any person who knowingly and with intent to defraud any insurance company or other person files an application for insurance or statement of claim containing any materially false information, or conceals for the purpose of misleading, information concerning any fact material thereto, commits a fraudulent insurance act, which is a crime and shall also be subject to: a civil penalty not to exceed five thousand dollars and the stated value of the claim for each such violation (in New York) or criminal and civil penalties (in Pennsylvania).

Notice to Washington Applicants: It is a crime to knowingly provide false, incomplete or misleading information to an insurance company for the purpose of defrauding the Company. Penalties include imprisonment, fines and denial of insurance benefits.

The **Applicant's** submission of this Supplemental Application does not obligate the Company to issue, or the **Applicant** to purchase, the Policy. The Company will advise the **Applicant** if the Supplemental Application for coverage is accepted. The **Applicant** hereby authorizes the Company to make any inquiry in connection with this Supplemental Application.

The undersigned authorized agents of the person(s) and entity(ies) proposed for this insurance declare that to the best of their knowledge and belief, after thorough review, the statements made in this Supplemental Application and in any attachments or other documents submitted with this Supplemental Application are true and complete. The undersigned agree that this Supplemental Application and such attachments and other documents shall be the basis of the contract should a Policy providing the requested coverage be issued; that all such materials shall be deemed to be attached to and shall form a part of any such Policy; and that the Company will have relied on all such materials in issuing any such Policy. The information requested in this Supplemental Application is for underwriting purposes only and does not constitute notice to the Company under any insurance of a Claim or potential Claim.

Applicant:_____

Signature:_____

Name:_____

Title:_____

Date:_____

The TPA represents that he/she is not aware of any other risk, other than those listed in this Supplemental Application.

TPA:_____

Signature:_____

Name:_____

Title:_____

Date:_____

[The Agent/Broker represents that he/she is not aware of any other risk, other than those listed in this Supplemental Application.

Agent/Broker:_____

Signature:_____

Name:_____

Title:_____

Date:_____]

ICD-9 Codes for Disclosure Notification

Please list all Plan Participants who have been diagnosed with or treated for any of the codes listed under the follov categories during the current Benefit Period:

001-139 Infectious and Parasitic Diseases
038-038.9 Septicemia
042 AIDS / HIV
070-070.9 Viral Hepatitis

140-239 Neoplasms
140-149.9 Malignant Neoplasm of Lip, Major Salivary Glands, Gum, Mouth, Oropharynx, Nasopharynx, and/or Hypopharynx
150-150.9 Malignant Neoplasm of Esophagus
151-151.9 Malignant Neoplasm of Stomach
153-153.9 Malignant Neoplasm of Colon
154-154.8 Malignant Neoplasm of Rectum
155-155.2 Malignant Neoplasm of Liver
157-157.9 Malignant Neoplasm of Pancreas
161-161.9 Malignant Neoplasm of Larynx
162-162.9 Malignant Neoplasm of Lung
170-170.9 Malignant Neoplasm of Bone
174-174.9 Malignant Neoplasm of Female Breast
179-182.8 Malignant Neoplasm of Uterus or Cervix
183-183.9 Malignant Neoplasm of Ovary
185 Malignant Neoplasm of Prostate
186-186.9 Malignant Neoplasm of Testis
188-189.9 Malignant Neoplasm of Bladder, Kidney, Urinary
191-191.9 Malignant Neoplasm of Brain
192-192.9 Malignant Neoplasm of Nervous System
194-194.9 Malignant Neoplasm of Endocrine Glands
195-195.8 Malignant Neoplasm of Other Ill-Defined Sites
196-196.9 Secondary Malignant Neo. Lymph Nodes
197-197.8 Secondary Malignant Neo. Respty and Digestive Systems
198-198.89 Secondary Malignant Neo. Other Specified Sites
200-208.9 Lymphoma and/or Leukemia
235 Neoplasm Uncertain Behavior
239.2 Neoplasm Unspecified Nature – Bone, Skin

240-279 Endocrine, Nutritional, Metabolic, Immunity
250-250.9 Diabetes
277.0 Cystic Fibrosis
278.0 Obesity/Hyperaliment

280-289 Diseases of the Blood and Blood-Forming Organs
282.6 Sickle-Cell Anemia
284.9 Aplastic Anemia NOS
286-286.9 Coagulation Defects and/or Hemophilia

320-389 Diseases of the Nervous System and Sense Organs
330 Cerebral degenera tions
344.0-344.09 Quadriplegia and Quadriparesis
331.0-331.9 Reye's Syndrome
344.1 Paraplegia
348.0-348.9 Encephalopathy
357, 358 Neuropathy / Myasthenia Gravis

390-459 Diseases of the Circulatory System
410-410.9 Acute Myocardial Infarction
411-411.89 Acute and Subacute Ischemic Heart Disease
414-414.05 Coronary Atherosclerosis (ASHD)
415-415.19 Acute Pulmonary Heart Disease
416-416.9 Chronic Pulmonary Heart Disease
417.1 Aneurysm of Pulmonary Artery
421-421.9 Acute and Subacute Endocarditis
424-424.9 Valve Disorders
425-425.9 Cardiomyopathy
426-426.9 Conduction Disorders
427-427.9 Cardiac Dysrhythmias
428-428.9 Heart Failure
430, 431 Subarachnoid / Intracerebral Hemorrhage
434.9 Occlusion of Cerebral Arteries
436 Acute Cerebrovascular Accident (CVA)
440-441.9 Atherosclerosis / Aortic Aneurysm

460-519 Diseases of the Respiratory System
480-486 Pneumonia
490-496 Chronic Obstructive Pulmonary Disease (COPD), etc.
515 Postinflammatory Pulmonary Fibrosis
518-518.89 Pulmonary Collapse and/or Respiratory Failure

520-579 Diseases of the Digestive System
555-555.9 Regional Enteritis (Crohn's Disease)
560.0-560.9 Intestinal Obstruction
562.1Diverticulitis of Colon
567-567.9 Peritonitis
569.0-569.9 Other Disorders of Intestine
570-571.9 Liver Diseases and Cirrhosis
572.8 Other Sequela of Chronic Liver Disease
573-573.9 Other Liver Disorders
577-577.9 Pancreas Diseases
578-578.9 Gastrointestinal Hemorrhage

580-629 Diseases of the Genitourinary System
584-584.9 Acute Renal Failure
585 Chronic Renal Failure
586 Renal Failure, Unspecified
588 Disorders resulting from impaired renal function
592 Calculus of Kidney & Uerter

630-677 Complications of Pregnancy, Childbirth
641.1 Placenta Previa
642.5-642.7 Eclampsia, pre-eclampsia
644.0-644.2 Premature Labor
648.0 Gestational Diabetes
651 Multiple Gestation
654.5 Cervical Incompetence

710-739 Diseases of the Musculoskeletal System and Connective Tissue
715.0-715.9 Osteoartrhosis
721.3 Lumbosacrel Spondylosis
722.0-722.9 Intervertebral Disc Disorders
730-730.9 Osteomyelitis and/or Periostitis
737.3 Kyphoscoliosis and scoliosis

740-759 Congenital Anomalies
747.2 Aortic Atresia / Stenosis
751.6 Biliary Atresia
759-759.9 Other and Unspecified Congenital Anomalies

760-779 Conditions Originating in the Perinatal Period
765-765.1 Prematurity
769 Respiratory Distress Syndrome
770.0-770.9 Other Respiratory Conditions of Newborn

780-799 Symptoms, Signs, and Ill-Defined Conditions
785-785.9 Symptoms Involving Cardiovascular System
786.5-786.59 Chest Pain

800-999 Injury and Poisoning
800-804.9 Fracture of Skull
805-805.9 Fracture of Vertebral Column
806-806.9 Fracture of Vertebral Column with Spinal Cord Injury
828-828.1 Multiple Fractures
853-854.1 Intracranial Injury
869-869.1 Internal Injury
887-887.7 Traumatic Amputation of Arm and Hand
897-897.7 Traumatic Amputation of Leg
949-949.5 Burns
952-952.9 Spinal Cord Injury
996-997.0 Complications peculiar to certain specified conditions
V23 Supervision of High-Risk Pregnancy
V42 – V58.9 Transplants, etc.

SERFF Tracking Number:	*CHUB-125276253*	*State:*	*Arkansas*
Filing Company:	*Federal Insurance Company*	*State Tracking Number:*	*AR-PC-07-026049*
Company Tracking Number:	*05-AP-8A-F*		
TOI:	*17.1 Other Liability - Claims Made Only*	*Sub-TOI:*	*17.1008 Employee Benefit Liability*
Product Name:	*ESL Stop Loss Supplemntal App Revision*		
Project Name/Number:	*ESL Stop Loss Supp App Revison/05-AP-8 A*		

Rate Information

Rate data does NOT apply to filing.

SERFF Tracking Number:	*CHUB-125276253*	*State:*	*Arkansas*
Filing Company:	*Federal Insurance Company*	*State Tracking Number:*	*AR-PC-07-026049*
Company Tracking Number:	*05-AP-8A-F*		
TOI:	*17.1 Other Liability - Claims Made Only*	*Sub-TOI:*	*17.1008 Employee Benefit Liability*
Product Name:	*ESL Stop Loss Supplemntal App Revision*		
Project Name/Number:	*ESL Stop Loss Supp App Revison/05-AP-8 A*		

Supporting Document Schedules

		Review Status:	
Satisfied -Name:	Uniform Transmittal Document-Property & Casualty	Approved	09/20/2007

Comments:

Completed NAIC Transmittal is attached

Attachment:

Arkansas Fee Filing Form.pdf

Effective March 1, 2007

Property & Casualty Transmittal Document

Reset Form

1. Reserved for Insurance Dept. Use Only	2. Insurance Department Use only
	a. Date the filing is received:
	b. Analyst:
	c. Disposition:
	d. Date of disposition of the filing:
	e. Effective date of filing:
	New Business
	Renewal Business
	f. State Filing #:
	g. SERFF Filing #: CHUB-125276252
	h. Subject Codes

3.	Group Name	Group NAIC #
	Chubb	038

4.	Company Name(s)	Domicile	NAIC #	FEIN #	State #
	Federal Insurance Company	IN	038-20281	1396346	

5.	Company Tracking Number	05-AP-8A-F

Contact Info of Filer(s) or Corporate Officer(s) [include toll-free number]

6.	Name and address	Title	Telephone #s	FAX #	e-mail
	Fran Muldoon 202 Hall's Mill Road, White House Station, NJ 08889	Manager State Filings	908 572 2875	9085724034	fmuldoon @chubb.com

7.	Signature of authorized filer	*Fran Muldoon*
8.	Please print name of authorized filer	Fran Muldoon

Filing information (see General Instructions for descriptions of these fields)

9.	**Type of Insurance (TOI)**	17.1 Other Liability-Claims Made Only
10.	**Sub-Type of Insurance (Sub-TOI)**	17.1008 Employee Benefit Liability
11.	**State Specific Product code(s)(if applicable)[See State Specific Requirements]**	
12.	**Company Program Title (**Marketing title)	Employer Stop Loss
13.	**Filing Type**	☐ Rate/Loss Cost ☐ Rules ☐ Rates/Rules ☑ Forms ☐ Combination Rates/Rules/Forms ☐ Withdrawal ☐ Other (give description)
14.	**Effective Date(s) Requested**	New: 10/8/2007 Renewal:
15.	**Reference Filing?**	☐ Yes ☑ No
16.	**Reference Organization (**if applicable)	
17.	**Reference Organization # & Title**	
18.	**Company's Date of Filing**	
19.	**Status of filing in domicile**	☑ Not Filed ☐ Pending ☐ Authorized ☐ Disapproved

Property & Casualty Transmittal Document—

20.	This filing transmittal is part of Company Tracking #	05-AP-8A-F

21. Filing Description [This area can be used in lieu of a cover letter or filing memorandum and is free-form text]

We are submitting for a revised supplemntal applicaton to repalce the form recently submitted and approved under our filing number)%-AP-8 F/R approval . The form was previously approved in your state on

This revise Application 14-03-0485-Supp EMPOLYER STOP LOSS SUPPLEMENTAL APPLICATION allows us to obtain information necessary to underwrite the Stop Loss program.

There is no impact on rating by the use of this fo

View Complete Filing Description

22. Filing Fees (Filer must provide check # and fee amount if applicable)
[If a state requires you to show how you calculated your filing fees, place that calculation below]

Check #: 00364283
Amount: $20

Refer to each state's checklist for additional state specific requirements or instructions on calculating fees.

*****Refer to the each state's checklist for additional state specific requirements (i.e. # of additional copies required, other state specific forms, etc.)**

Effective March 1, 2007

FORM FILING SCHEDULE

(This form must be provided ONLY when making a filing that includes forms)

(Do not refer to the body of the filing for the forms listing, unless allowed by state.)

1.	**This filing transmittal is part of Company Tracking #**	05-AP-8A-F
2.	**This filing corresponds to rate/rule filing number** (Company tracking number of rate/rule filing, if applicable)	N/A

3.	**Form Name /Description/Synopsis**	**Form # Include edition date**	**Replacement Or withdrawn?**	**If replacement, give form # it replaces**	**Previous state filing number,** if required by state
01	Employer Stop Loss Supplemental Application	14-03-0485-SuppA (8/2007)	☐ New ☑ Replacement ☐ Withdrawn	14-03-0485-Supp	
02			☐ New ☐ Replacement ☐ Withdrawn		
03			☐ New ☐ Replacement ☐ Withdrawn		
04			☐ New ☐ Replacement ☐ Withdrawn		
05			☐ New ☐ Replacement ☐ Withdrawn		
06			☐ New ☐ Replacement ☐ Withdrawn		
07			☐ New ☐ Replacement ☐ Withdrawn		
08			☐ New ☐ Replacement ☐ Withdrawn		
09			☐ New ☐ Replacement ☐ Withdrawn		
10			☐ New ☐ Replacement ☐ Withdrawn		

PC FFS-1

RATE/RULE FILING SCHEDULE

(This form must be provided ONLY when making a filing that includes rate-related items such as Rate; Rule; Rate & Rule; Reference; Loss Cost; Loss Cost & Rule or Rate, etc.)

(Do not refer to the body of the filing for the component/exhibit listing, unless allowed by state.)

1.	**This filing transmittal is part of Company Tracking #**	N/A

2.	**This filing corresponds to form filing number** (Company tracking number of form filing, if applicable)	05-AP-8A-F

☐ Rate Increase ☐ Rate Decrease ☐ Rate Neutral (0%)

3.	**Filing Method (Prior Approval, File & Use, Flex Band, etc.)**	

4a. Rate Change by Company (As Proposed)

Company Name	Overall % Indicated Change (when applicable)	Overall % Rate Impact	Written premium change for this program	# of policyholders affected for this program	Written premium for this program	Maximum % Change (where required)	Minimum % Change (where required)

4b. Rate Change by Company (As Accepted) For State Use Only

Company Name	Overall % Indicated Change (when applicable)	Overall % Rate Impact	Written premium change for this program	# of policyholders affected for this program	Written premium for this program	Maximum % Change	Minimum % Change

5. Overall Rate Information (Complete for Multiple Company Filings only)

		COMPANY USE	STATE USE
5a	**Overall percentage rate indication (when applicable)**		
5b	**Overall percentage rate impact for this filing**		
5c	**Effect of Rate Filing – Written premium change for this program**		
5d	**Effect of Rate Filing – Number of policyholders affected**		

6.	**Overall percentage of last rate revision**	
7.	**Effective Date of last rate revision**	
8.	**Filing Method of Last filing (Prior Approval, File & Use, Flex Band, etc.)**	

9.	**Rule # or Page # Submitted for Review**	**Replacement or withdrawn?**	**Previous state filing number, if required by state**
01		☐ New ☐ Replacement ☐ Withdrawn	
02		☐ New ☐ Replacement ☐ Withdrawn	
03		☐ New ☐ Replacement ☐ Withdrawn	